Committee On Finance
Max Baucus, Chairman

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Baucus Statement on the Beneficiary Access to Care and Medicare Equity Act of 2002

Today, along with Senator Grassley, we are introducing the "Beneficiary Access to Care and Medicare Equity Act." This legislation is critical to ensuring access to quality, affordable health care for the 40 million Medicare beneficiaries nationwide.

Medicare is one of America's great success stories. Since its inception 36 years ago, Medicare has provided millions of elderly and disabled Americans with insurance coverage they would not have otherwise had. When Medicare was enacted, about half of America's elderly lacked health insurance. Now nearly all are covered by Medicare.

There are some who will argue that Congress has more pressing Medicare priorities to address than restoring payments to health care providers. They will argue that before action on a bill concerning Medicare payment policy is taken up, Congress should debate and enact a solid prescription Medicare drug benefit.

I agree wholeheartedly with the need for a good drug benefit. Like many of my colleagues, I believe this issue is critical and that no one -- not Congress or this Administration -- can give up on such an important issue that will directly affect millions of American lives.

The lack of a drug benefit is the greatest deficiency in the Medicare program today. Almost 40 percent of seniors currently lack drug coverage. And for those who have it, it is often unreliable and unaffordable.

I did my utmost to pass a drug benefit this year, and I will continue my efforts until one is signed into law. But I will not support a benefit that is unworkable for my state. And I will not support reviving a prescription drug debate that threatens passage of the important bill Senator Grassley and I are introducing today.

The United States Senate debated Medicare prescription coverage in July. We had four votes on four different proposals to establish a drug benefit under Medicare. But all of those votes failed. None came close to getting the required 60 votes for passage in the Senate.

Voting again on a prescription drug bill that has not changed materially from the proposals we voted on in July is not the way to pass a drug benefit. In fact, it's a prescription for legislative gridlock - on prescription drugs and on provider reimbursement issues.

For these reasons, I urge my colleagues to support this legislation - with the recognition that there are other pressing issues facing the Medicare program besides provider payments, but with the acknowledgment that maintaining access to health care services is also an important goal.

Over the past three decades, Medicare has undergone significant changes - including changes in the way that health care providers are reimbursed. In response to rising Medicare expenditures, Congress has responded with complex cost-containment mechanisms: diagnosis related groups, or DRGs, for hospital inpatient services in the early 1980s, a fee schedule for physicians' services in 1989. And in 1997, Congress passed the Balanced Budget Act, which mandated prospective payment systems for hospital outpatient departments, home health agencies, and skilled nursing facilities. Gradually, Medicare has changed from a cost-based system to one of prospective, flat-rate payment.

The significant changes in payment policy have resulted in a few bumps along the way, particularly those enacted as part of the Balanced Budget Act of 1997. The BBA was a well-intended attempt to get our Nation's fiscal house in order and extend the life of the Medicare trust fund. And in that regard, the goal of the legislation was achieved. But in some instances, the BBA cuts went too far.

In such cases, these cuts threatened to reduce Medicare and Medicaid beneficiaries' access to quality medical care and services. Congress responded but we still find that in some cases more improvements and adjustments are needed. And that is why Senator Grassley and I are introducing this bill today.

So what does this bill do? Most importantly, this bill would restore payments to physicians, which were cut in 2002 by about five percent. Under the Medicare fee schedule, payment for physician services depends on several factors, including the growth in medical inflation, performance of the American economy, and changes in law and regulation.

Also central to the calculation of payments are estimates by the Centers for Medicare and Medicaid Services (or CMS, which was formerly known as the Health Care Financing Administration) of the numbers of Medicare beneficiaries in traditional fee-for-service Medicare. Largely because of significant estimation errors and a weakened economy, physicians under Medicare experienced an average payment reduction of five percent in 2002. If Congress does not act to fix the system, further large cuts are forecast for the coming years. And the potential consequences of inaction are serious.

According to a 30-state survey by the Medicare Rights Center, Medicare beneficiaries in 15 states and the District of Columbia are already having trouble finding a physician who accepts new Medicare patients. And researchers from the Center for Studying Health System Change have found that the percentage of Medicare beneficiaries who reported delaying or not getting necessary physician care rose from 9.1 percent in 1997 to 11 percent in 2001. The study also showed that of the near-elderly, patients between 50 and 64, 18.4 percent experienced difficulty in seeing a physician in 2001, up from 15.2 percent in 1997.

This bill would provide positive payment updates to the physician fee schedule over the next three years, representing a dramatic turnaround in Medicare physician payments. It would also modify the formula that is used to increase payments each year - the so-called SGR, which most physicians have learned to view with uncertainty and distrust.

While this proposal on physician updates represents progress, I acknowledge that it is imperfect, producing large reductions in Medicare physician payments in 2006 and beyond. I am committed to working with my colleagues in the Congress and the Administration to find a more reasonable solution.

Aside from physician payments, this legislation addresses a number of other important Medicare reimbursement issues, many of which are set to take effect today, October 1. The bill will completely eliminate the 15 percent cut in home health payments. It will forestall large cuts to indirect medical education, so critical to the well-being of our nation's teaching hospitals. And the bill will continue additional payments to nursing homes to help them hire more staff to care for patients.

It should come as no surprise that another priority of mine - and Senator Grassley's - is ensuring that rural areas are treated on par with their urban counterparts. I represent a state with a population density of about six people per square mile - where patients and providers are often separated by vast distances. The current Medicare payment structure does not adequately account for the unique circumstances and challenges of providing medical care in such areas, where economies of scale often make systems like prospective payment unworkable.

That's why I was proud to help write the Sole Community Hospital law in the early 1980s and the Critical Access Hospital (CAH) program in 1997. Based on the Montana Medical Assistance Facility program, or MAF, the CAH concept has been a lifeline for over 600 rural communities nationwide, allowing hospitals that might have otherwise closed to stay open. This bill makes a number of important changes to the CAH program, including a provision allowing greater flexibility in the use of acute care and swing beds, as well as reauthorization of the Rural Hospital Flexibility Grant Program, which assists facilities in making the switch to CAH status.

Aside from Critical Access Hospitals, this legislation makes a number of other important changes to bring Medicare equity to rural America. By making the Medicare

Incentive Payment Program (MIPP) automatic, physicians can more easily receive their 10 percent bonus for practicing in health professional shortage areas. And by setting a floor for the physician work component of Medicare's geographic cost index, payments to rural physicians will be raised.

This bill also puts rural and urban areas on a more level playing field with respect to non-CAH hospital payments. It equalizes the base payment rate for all PPS hospitals, eliminating the differential in the so-called "standardized amount, "which systematically pays rural areas less than large urban ones. And it makes Disproportionate Share Hospital (DSH) payments more equitable by allowing rural facilities to receive increased payments for treating indigent patients.

Many of these provisions are based on the work and recommendations of the Medicare Payment Advisory Commission (MedPAC) in their report on rural Medicare policy. That report included telling statistics, and reinforced what I hear from my constituents on a regular basis: Medicare payment policy disadvantages rural areas and changes are needed. For example, in 1999, overall Medicare margins for rural hospitals with 50 beds or less were negative 5.4 percent, worse than any other category of hospital. And total margins for these hospitals are also the lowest, at 1.7 percent in 1999, compared to 3.6 percent for all hospitals. Clearly Congress has work to do to ensure greater geographic equity in Medicare payment, and this bill makes great strides to that end.

This legislation also contains important relief for providers struggling with Medicare's regulatory framework. Many of these regulatory relief provisions were contained in legislation I wrote with Senators Kerry, Murkowski and Grassley last year. Among other things, these provisions will: ensure that health care providers have their questions of CMS answered in a timely manner; give additional appeal rights to providers, so that they receive fair treatment for honest billing mistakes; and ensure that demands to return overpayments are reasonable and do not force small providers to declare bankruptcy, thereby threatening access to health care services in rural areas.

In addition to Medicare provisions, this legislation addresses many critical issues related to Medicaid and the State Children's Health Insurance Program. The bill provides $5 billion in fiscal relief to states struggling with tight Medicaid budgets and nearly $3 billion to help safety net hospitals continue to provide critical health care services to low-income Americans. The bill also ensures the continued success of the S-CHIP program by giving states more time to spend their S-CHIP allotments and ensuring that as many children as possible are covered.

The bill provides immediate, temporary fiscal relief to states in two ways: by giving states a temporary increase in their Medicaid match rate, or FMAP; and by increasing funding for the Social Services Block Grant. Taken together, these two approaches will help alleviate the pressure on states to cut programs that serve low income families, children, seniors and the disabled.

The state fiscal relief provision recognizes that states are in the midst of their worst fiscal crisis since the early 1990s. States have cut their budgets across many programs, from education to health care to other social programs. And because Medicaid is one of the largest parts of state budgets, Medicaid continues to be a prime target for spending cuts.

According to a recent report from the Kaiser Commission on Medicaid and the Uninsured, 45 states took action to reduce their Medicaid spending growth in fiscal year 2002, and 41 states are planning further reductions in fiscal year 2003. In my own state of Montana, Medicaid beneficiaries have been asked to pay a larger share of the costs of their coverage, and provider reimbursement rates have been cut.

These program cuts have come about at the same time that Medicaid rolls are increasing due to the recession. As more people lose their jobs and health insurance - just yesterday, we learned that in 2001 another 1.4 million people joined the ranks of the uninsured - many become eligible for Medicaid. At the same time, states are forced to cut back on this vital safety net program when people need it most. This is a vicious cycle that we must help end. If we don't, the ultimate result of all this is an increase in the uninsured. Just as we saw in the early 1990s.

The financial crisis facing state Medicaid programs is also felt the facilities that provide care to Medicaid beneficiaries and low-income insured populations. To ensure that hospitals serving our most vulnerable populations can continue providing their vital services, this bill eliminates the scheduled reduction in federal Medicaid funding for hospitals that serve a disproportionate share of Medicaid beneficiaries and low-income, uninsured patients. Without the restoration of these DSH funds, safety net hospitals would lose nearly $3 billion in federal Medicaid funding over the next three years. States with smaller DSH programs will also benefit through this legislation, as it provides them with greater resources to serve their low-income patients.

This bill also seeks to continue the unqualified success of the S-CHIP program by ensuring that S-CHIP funds are used to cover as many children as possible, as efficiently and effectively as possible. By giving states an additional year to spend funds that would otherwise be returned to the federal Treasury and renewing the ongoing system to allocate unspent S-CHIP funds equitably among the states, the legislation will help sustain the significant progress S-CHIP has made in reducing the ranks of uninsured children. In addition, the new caseload stabilization pool will provide additional funds to states expected to have insufficient federal funds over the next few years, reducing the chance that children will be dropped from the rolls.

This bill would also make important improvements to the Medicaid and S-CHIP waiver process. Medicaid and S-CHIP waivers have become an increasingly powerful way for the Secretary of Health and Human Services to make changes to crucial health programs without having to consult with, or seek legislative change from, the Congress.

The General Accounting Office recently identified serious problems with the current waiver approval process, including a lack of accountability in several areas. I am pleased to have worked with Senator Grassley to develop legislation that would address the key GAO recommendations and begin to restore integrity to the waiver process. More specifically, this bill would require that the waiver process be more transparent and require public notification when major changes are in store.

Our bill would also prohibit approval of future waivers that would take dollars set aside for children's health and use them instead on childless adults. Where Congress has set limits on the use of federal dollars, waivers should not be used as a back door way to get around those limits.

Without question, the Medicaid and S-CHIP programs are vital components of America's health care safety net, and both programs are critical to the well-being of thousands in my state. The Billings Gazette reported yesterday that about 14,000 of the 18,000 newly-insured Montanans since 1999 were additions to Montana's Medicaid and S-CHIP programs.

But despite the critical role these programs play, I am not convinced that we know enough about our nation's health care safety net. Based on legislation I introduced last congress with Senator Grassley, the bill we are introducing today would change that, by establishing the Safety Net Organizations and Patient Advisory Commission. SNOPAC would be an independent and nonpartisan commission charged with the authority to oversee all aspects of America's health care safety net, including Medicaid and S-CHIP. Based on an Institute of Medicine report, SNOPAC will include health care experts from the disparate parts of our safety net system, reporting to Congress on recommendations to maintain our intact, but endangered, health care safety net.

Today is October 1, the first day of the new fiscal year. Significant Medicare, Medicaid and S-CHIP payment reductions and changes are taking effect. Congress should act as soon as possible to address these issues, to get something done, and to ensure access to care for our seniors, our children, and our disabled population. This bill is necessary, timely and should be considered with expedition. I urge Congress and the President to act swiftly on this comprehensive legislation and enact it into law.